

Shielding Plan Review Application

TO BE COMPLETED BY APPLICANT:

Facility Name _____

Contact Person and Title _____

Telephone # _____

Facility Type _____ County: _____

Current Mailing Address _____

Facility Street Address _____

Facility Status: ☐ New ☐ Relocation ☐ Other (specify) _____

Equipment Status: ☐ New ☐ Replacement ☐ Relocation within facility ☐ Other (specify) _____

Name of shielding vendor _____

Registration # of shielding vendor _____

Address and telephone # of shielding vendor _____

Name and title of person submitting this information _____

Date _____ Telephone # _____

Please return:

- 1. The application**
- 2. Shielding Plan**
- 3. \$62.50 Shielding plan review fee**

To:

Shielding Plan Registration
DHEC Radiological Health
2600 Bull Street
Columbia, SC 29201

Please contact us at (803) 545-4400 if there are any questions. The shielding plan cannot be evaluated without this form and the shielding plan review fee.

DHEC USE ONLY: Registration # _____ Check _____